

COMPLETE ENTIRE FORM TO AVOID DELAYS

PATIENT INFORMATION					
Name (Last, First, MI)		Date of Birth (MM/DD/YY)	Date of Death (if applicable)	Phone Number/Email	
Address	City	State	Zip	Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish (Ashkenazi) <input type="checkbox"/> Portuguese <input type="checkbox"/> Other:
SPECIMEN INFORMATION* (For phlebotomy service, select all services you are requesting)					
Type(s) <input type="checkbox"/> Blood (EDTA preferred) <input type="checkbox"/> Saliva <input type="checkbox"/> DNA <input type="checkbox"/> Cord Blood** <input type="checkbox"/> Other**:			<input type="checkbox"/> Personal history of allogenic bone marrow or peripheral stem cell transplant		
Collection Date	Specimen ID		Medical Record #		
<p>*Blood or saliva from patients with active/recent hematological disease will undergo additional review and may not be accepted in some cases. For these, cultured fibroblasts or fresh/fresh frozen normal tissue are preferred. See ambrygen.com/specimen-requirements for details.</p> <p>**If submitting Cord Blood or a fetal specimen, please see bottom of page 3 for Maternal Cell Contamination sample submission test codes.</p>					
Phlebotomy Services Request: <input type="checkbox"/> Phlebotomy draw <input type="checkbox"/> Insurance preverification first <input type="checkbox"/> Send kit to patient* *As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient(s). I understand that the phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and/or patient(s) are in question.					
ORDERING PHYSICIAN/SENDING FACILITY (Each listed person will receive a copy of the report)					
Facility Name (Facility Code)		Address	City	State /Country	Zip Phone
Ordering Licensed Provider Name (Last, First)(Code)		NPI#	Phone	Fax/Email	
ADDITIONAL RESULTS RECIPIENTS					
Genetic Counselor or Other Medical Provider Name (Last, First) (Code)			Phone/Fax/Email		
CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING					
The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambry Genetics to facilitate the provision of pre-test genetic counseling services by a third party service, Informed DNA (unless otherwise noted), as required by the patient's insurance provider (unless this box is checked <input type="checkbox"/>). Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.					
Signature Required for Processing Medical Professional Signature:				Date:	
INSURANCE BILLING (Include copy of both sides of insurance card)			INSTITUTIONAL BILLING		
Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Name and DOB of Policy Holder (if not self)	Facility Name		<input type="checkbox"/> Send invoice to facility address above
Insurance Company	Policy #	HMO Auth #	Address		
Out Of Pocket: Ambry Genetics will start testing immediately. We will attempt to contact the patient if: <input type="checkbox"/> Out-of-pocket amount is greater than \$100 (default) <input type="checkbox"/> There is any out-of-pocket amount <input type="checkbox"/> Do not initiate testing until patient is contacted and approves payment terms regarding out-of-pocket Patient agrees to contact regarding out-of-pocket amount by: <input type="checkbox"/> Email <input type="checkbox"/> Phone (includes texts) - confirm mobile # _____			Contact Name		
			Phone Number	E-mail/Fax	
<input type="checkbox"/> GRATIS (Check for pre-approved gratis testing)			<input type="checkbox"/> PATIENT PAYMENT		<input type="checkbox"/> Check (Payable to Ambry Genetics) <input type="checkbox"/> Credit Card (Call 949-900-5795)
Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company.					
For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambry's Patient Assistance Program, please provide the total annual gross household income: \$ _____ and the number of family members in the household supported by the listed income: _____. I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.					
FOR NY RESIDENTS:					
<input type="checkbox"/> I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. NOTE: If left blank, consent is interpreted as "NO".					
Signature Required For Insurance/Self-Pay Patients and NY Sample Storage Consent:				Date:	

Cardiovascular Test Requisition Form - Page 2 of 3

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)
 Diagnostic Family history Positive or normal control Other _____

ICD-10 code(s): _____

 Will patient management be changed depending on the test results? Yes No

CLINICAL HISTORY

<p>PLEASE SUPPLY CLINIC NOTES AND PEDIGREE</p> <input type="checkbox"/> No personal history of cardiovascular disease	<input type="checkbox"/> Congenital Heart Defect Type: _____
Sudden cardiac arrest <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____ # Episodes: _____ Age first incident: _____	<input type="checkbox"/> Ectopia lentis <input type="checkbox"/> Myopia
Syncope <input type="checkbox"/> Y <input type="checkbox"/> N (if yes): # Episodes: _____ Age first incident: _____	<input type="checkbox"/> Marfanoid habitus
History of cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> HCM <input type="checkbox"/> DCM <input type="checkbox"/> ARVC <input type="checkbox"/> LVNC <input type="checkbox"/> RCM <input type="checkbox"/> Other cardiomyopathy Types: _____	<input type="checkbox"/> Pectus deformity Type: _____
History of Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N Age at dx: _____ <input type="checkbox"/> Long QT <input type="checkbox"/> Short QT <input type="checkbox"/> Brugada <input type="checkbox"/> CPVT <input type="checkbox"/> ARVC <input type="checkbox"/> Other arrhythmia Types: _____	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Joint Hypermobility <input type="checkbox"/> Joint contractures
Other features/syndromes <input type="checkbox"/> Clinical diagnosis of Marfan Syndrome <input type="checkbox"/> Aortic Aneurysm/Dilation Age at dx: _____ <input type="checkbox"/> Other Aneurysm Location: _____ Age at dx: _____ <input type="checkbox"/> Aortic/Vascular Dissection Location: _____ Age at dx: _____ <input type="checkbox"/> Arterial tortuosity <input type="checkbox"/> BAV <input type="checkbox"/> MVP	<input type="checkbox"/> Pneumothorax <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Facial clefting, Type : _____ <input type="checkbox"/> Xanthoma(s) <input type="checkbox"/> Epistaxis (nosebleeds) <input type="checkbox"/> Telangiectasia <input type="checkbox"/> AVM Location: _____ <input type="checkbox"/> Amyloidosis Age at dx: _____ <input type="checkbox"/> Neuromuscular disease Specify: _____ <input type="checkbox"/> Hearing Loss Describe: _____ <input type="checkbox"/> Genetic syndrome Specify: _____ <input type="checkbox"/> Other Specify: _____

CLINICAL TESTING AND PROCEDURES

LDL-C: _____ Total Cholesterol: _____ Age at Testing: _____

Procedures (e.g.: EKG, ECHO, etc.) Age: _____ Result (e.g.: LVIDd, PWd, Qtc, etc): _____ Type: _____
 Age: _____ Result (e.g.: LVIDd, PWd, Qtc, etc): _____ Type: _____

Cardiovascular Device implant (eg: Pacemaker, ICD, LVAD, etc.): Age at implantation: _____ Type: _____

Additional History: _____

PREVIOUS GENETIC TESTING (PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS) No previous molecular and/or genetic testing

Karyotype or microarray analysis: _____

Test	Laboratory	Results

FAMILY HISTORY* None (maternal) None (paternal) Maternal hx unknown Paternal hx unknown

*Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigrees and other clinical family history notes should be supplied as well when sending in your order.

Relation to patient	Maternal	Paternal	H/o cardio disease	Dx age
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

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REQUIRED ORDERING CHECKLIST

- Clinic notes (with pedigree if available)
- ICD-10 code(s)
- Clinician & patient signatures
- Insurer-specific forms (i.e. ABN), if applicable
- Front/back copy of insurance card(s)

Please check the box next to the test(s) being ordered below. All tests include gene sequence and deletion/duplication analyses unless otherwise indicated.

If this TRF is sent to Ambry without or ahead of the sample, it will be treated as a preverification. If test ordered is different than the test preverified, we will honor what is on the TRF order form with the sample.

For multiple test orders, testing will be run concurrently (multiple tests initiated at the same time) unless otherwise specified. To order reflexive testing (second test starts pending first test outcome), please clearly indicate the order of reflexive tests in the notes section or next to the test check box. For reflex test orders, any positive findings (pathogenic/likely pathogenic) in the first test will be reported out to the clinician, and the requested second test will be canceled; all other findings will automatically reflex (including VUS).

Check to order	Test Name	Test Code	Description
Cardiomyopathy Panels			
<input type="checkbox"/>	HCMFirst	8935	First tier test of 2 most common genes for hypertrophic cardiomyopathy (MYBPC3, MYH7)
<input type="checkbox"/>	HCMNext	8936	27 genes for hypertrophic cardiomyopathy
<input type="checkbox"/>	HCMNext Reflex	8883	HCMFirst reflex to HCMNext
<input type="checkbox"/>	DCMNext	8884	36 genes for dilated cardiomyopathy
<input type="checkbox"/>	CMNext with TTN	8887	55 genes for hereditary cardiomyopathy
<input type="checkbox"/>	ARVCNext	8904	9 genes for arrhythmogenic right ventricular cardiomyopathy
<input type="checkbox"/>	LVNCNext	8906	8 genes for left ventricular non-compaction
Comprehensive Cardiovascular Panels			
<input type="checkbox"/>	CardioNext with TTN	8911	85 genes for hereditary cardiomyopathies and arrhythmias
<input type="checkbox"/>	CustomNext-Cardio	9520	Up to 106 gene custom hereditary cardiomyopathies and arrhythmias test. Required: completed CustomNext-Cardio supplemental form. ambrygen.com/forms
Arrhythmia, Long QT, and Brugada Panels			
<input type="checkbox"/>	RhythmFirst	8888	12 genes for long QT, Brugada, and short QT syndromes
<input type="checkbox"/>	RhythmNext	8900	36 genes for long QT syndrome, Brugada syndrome, and other inherited arrhythmias
<input type="checkbox"/>	RhythmNext Reflex	8901	RhythmFirst with reflex to RhythmNext
<input type="checkbox"/>	CPVTNext	8902	6 genes for catecholaminergic polymorphic ventricular tachycardia
Aneurysms and Related Disorders			
<input type="checkbox"/>	TAADNext	8789	22 genes for thoracic aortic aneurysms/dissections
<input type="checkbox"/>	Marfan syndrome	8781	FBN1
<input type="checkbox"/>	Marfan reflex to TAADNext	8783	FBN1 reflex to TAADNext
<input type="checkbox"/>	Ehlers-Danlos vascular type (EDS IV)	8790	COL3A1
<input type="checkbox"/>	Ehlers-Danlos reflex to TAADNext	8791	COL3A1 reflex to TAADNext

Check to order	Test Name	Test Code	Description
Familial Hypercholesterolemia			
<input type="checkbox"/>	FHNNext	8680	4 genes (APOB, LDLR, LDLRAP1, PCSK9)
<input type="checkbox"/> Check this box if you would like to have the SLC01B1 c.521T>C polymorphism reported, which has been associated in medical literature with statin-induced myopathies			
Hereditary Hemorrhagic Telangiectasia (HHT)			
<input type="checkbox"/>	HHTNext	8672	5 genes for HHT
Noonan and Related Syndromes			
<input type="checkbox"/>	Noonan syndrome	8402	PTPN11, SOS1, KRAS, RAF1
Other Cardiovascular Genetic Tests			
<input type="checkbox"/>	Transthyretin amyloidosis	1560	TTR
OTHER ORDER			
Please visit ambrygen.com/tests for details.			
Test Code: _____ Test Name: _____			
SINGLE SITE ANALYSIS (Please include a copy of relative's report)			
Gene(s): _____ Mutation(s): _____			
Relative Name: _____			
Relationship to Relative: _____			
Accession # (If tested at Ambry): _____			
Positive control sample: <input type="checkbox"/> will be provided <input type="checkbox"/> already at Ambry <input type="checkbox"/> not available			
FOR PRENATAL SPECIMENS OR CORD BLOOD: MATERNAL CELL CONTAMINATION (Both test codes required for fetal specimens)			
<input type="checkbox"/> 1260 MCC for fetal specimen or cord blood (run concurrently with test)			
<input type="checkbox"/> 1262 MCC Reference for maternal blood sample (No Charge)			